favorable. On multiple occasions (as literature well documents) we have seen a dramatic rise in the systolic blood pressure within moments after the inflation of this suit. While this must not preclude definitive operation, it does in many cases remove patients from shock and maintain them while they are being prepared for laparotomy, thereby avoiding many of the sequelae of the shock state. The use of the MAST can have a net negative effect unless several potential problems are borne in mind. Its use precludes intravenous infusion via the lower extremities and thus necessitates several upper extremity lines; its use markedly elevates the diaphragms, and closed tube thoracostomy must be performed through a higher intercostal space and with much greater care; and perhaps the greatest risk is an unfounded feeling of confidence by the physician resulting in delays in definitive management and underestimation of volume requirements.

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Dr. Trunkey Replies

TO THE EDITOR: I very much appreciated reading Dr. Jergen's letter. The first point, about the awareness of the cervical spinal cord injury, is an excellent one. In fact, in every patient who is in this category at San Francisco General Hospital a lateral cervical spine film is taken before the patient is moved on to the emergency-trauma table. An exception to this is when a patient comes in with cardiac arrest. In that instance, the anesthesiologist usually maintains the patient's head in an axial alignment and moves right along with the intubation.

In regard to the second point, on the use of Medical Anti-Shock Trousers (MAST), I am also in full agreement. We have previously commented on the use of this device in an earlier Trauma Rounds (Lim RC: Abdominal vascular injuries [Trauma Rounds]. West J Med 123:321-324, Oct 1975).

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Pseudoacetylcholine

TO THE EDITOR: Dr. Morris Vilkin's letter to the editor in the July issue is entitled "Grip Test for Pseudoacetylcholine" and discusses patients with "high titre of pseudoacetylcholine." This is physiological nonsense and I am surprised that the editors allowed it to be printed without correction.

There is, of course, no such thing as pseudoacetylcholine. The abnormal sensitivity to succinylcholine found in some patients is due to a genetic deficiency in the plasma cholinesterase enzyme also known as pseudocholinesterase. The "pseudo" prefix is used because it is not the same enzyme as the cholinesterase which is present in nervous tissue and erythrocytes and which is highly specific in its action, the hydrolysis of acetylcholine.

Pseudocholinesterase on the other hand, promotes the hydrolysis of several choline esters including succinylcholine. In its absence, therefore, the action of succinylcholine is greatly prolonged with the resultant syndrome of persisting weakness of respiratory and other muscles.

Dr. Vilkin's grip test may be a valid screening technique for plasma cholinesterase deficiency. But to allow expressions such as "high titre of pseudoacetylcholine" to appear in print in the pages of a scientific journal can only promote confusion and misunderstanding about a subject of considerable importance.

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Health Care Costs

TO THE EDITOR: I usually find the editorials in the WESTERN JOURNAL astute and throught-provoking, but two that appeared in the June 1977 issue had some serious lapses.

In the first editorial, "Health Care Costs—A Call for AMA Leadership," it is stated "In the not too distant future the rising costs of the nation's health enterprise will equal or exceed the portion of the gross national product (GNP) that can be available for this purpose. In the opinion of some responsible persons this will happen when health-related costs reach approximately 9 per-